

Careful starving

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Chapter Four

Careful Starving: Reflections on (Not) Eating, Caring and Anorexia

Anna Lavis

Engaging with the volume's interrogation of what is 'brought to the table' by exploring interplays between care and food across diverse contexts, this chapter engages with the question, why and how does *not* eating engender or mobilize care? To explore this, it draws on data from two qualitative studies within large NHS inner-city mental health hospitals in England: The first involved participant observation and interviews with service users in an eating disorders inpatient unit (2007-2008) and the second comprised interviews with users of eating disorders outpatient, daypatient and inpatient services (2013-2014). By engaging with individuals diagnosed with anorexia, alongside clinical and ethical discussions of treatment, this chapter traces how competing paradigms of caring and eating, illness and selfhood, touch edges in the bodies and lives of individuals living with anorexia. In so doing, it widens the question posed above to ask what food and care both *are* and *do* in the myriad moments of their embodied encounters.

In clinical terms, the self-starvation of anorexia nervosa is regarded as lacking in self-care and propelled by a loss of agency to the illness. This conceptualizes food not only as *the* vector through which to care for an individual with anorexia, but also as that which (re-)produces their self-care, where that comes to mean, literally, care of the self. Feeding (as eating

through caring) is positioned as forging a teleological pathway from a current illness to a future anorexia-free self. In the clinic (see Foucault 2003) food is thus, ‘an essential therapeutic intervention’ (Powers and Cloak 2013: 82) not only for the integrity of the suffering body but also for the recovery of selfhood. However, engaging with individuals with anorexia elucidates not only how such care may be experienced as care-less, but also that embodied practices of not eating engender alternative modes of attention; anorexia, although recognized by participants as an illness, offers ways of caring both for oneself and for Others. Such caring through not eating maintains both anorexia and selfhood as the illness maps and matters the space of the present moment in ways that render it endurable.

Reflecting on entanglements between food and care in anorexia, then, constitutes an argument for an analysis of anorexia that both engages with the lived vulnerabilities of material bodies whilst also going beyond a focus on emaciation as a goal of self-starvation (see also Gooldin 2008; Lavis 2013, 2014; Warin 2010). Yet, this is also not to ignore the enormous suffering that anorexia can cause or to regard practices of not eating as either fully agential or lacking in agency. There is no doubt that eating disorders are often, as Bob Palmer puts it, ‘miserable and life blighting’ (2014: iii) illnesses, but they also emerge from research participants’ narratives as integral to selfhood. As such, the distress that anorexia causes is intertwined with individuals’ ways of caring for self and Others both through and in spite of the illness. Exploring entanglements of food and care traces the texture and sociality of not eating practices, allowing anorexia’s clinical realities to remain acknowledged but ‘bracketed’ (see Biehl and Locke 2010: 318) in order that other narratives may also be heard.

Central to this inquiry is the concept of ‘foodwork’. This has previously been used in relation to the feeding practices that are part of caregiving in clinical/residential settings, such as with individuals with dementia (cf. Heaven et al. 2013; Pierson 1999). In that context, foodwork’s meaning is shaped by the analogous term, ‘bodywork’; this has been described as

the ‘ambivalent, hidden work that tends to remain unarticulated within official discourses’ of care (Twigg 2006: 136. See also Mol et al. 2010b). Recognizing bodywork as the conceptual underpinning of foodwork highlights the emotional labour and boundary-crossing intimacies of caring for another’s body in feeding as much as in other activities such as washing (cf. Twigg 2002; Pols 2013). As such, whilst holding firmly within its parametres a sense of how eating and feeding may be vectors of care, the concept of foodwork also highlights the potential tensions and regimes of value embedded in such mobilizations of caring. Foodwork is thereby a productive concept; it allows us to hold together in one analytical space the (not) eating practices of individuals with anorexia, which we might term careful eating, and the feeding practices of the clinic, which we could term care-full feeding. Exploring each of these as diverse modalities of foodwork offers insights into ways in which performances of caring *about* and *for* (Fisher and Tonto 1990) entangle food and bodies, and comprise both emotional labour and value constructions.

Yet, while these modalities of caring may sometimes clash, sometimes co-exist and often ‘map onto different dimensions’ (Mol 2010: 217), there are also convergences between the clinic and individuals with anorexia. Although the chapter begins with mobilizations of eating through caring on the eating disorders unit (EDU), and goes on to explore how individuals’ practices of not eating mobilize alternative pathways of caring, the flows of directionality are not so neat; these directional entanglements between food and care do not overlay the two empirical contexts in such a binary way. It is particularly by paying attention to shifting positionings of the body that overlaps and mimeses emerge. Food, bodies and care are all negotiated in relation to one another. Foodwork therefore emerges as a ‘complex and embodied activity’ (Pierson 1999: 130) on the part of the clinic and research participants whilst also being related to bodily materialities and embodiment in uncertain ways. Diverging conceptualizations of anorexia(s) and selves enacted through food and care produce, as well as

intervene in, particular bodies. As such, this chapter echoes Annemarie Mol by asking, ‘what kind of matter is food? What kinds of bodies does it feed?’ (Mol 2012: 2), and suggests that care offers a productive way to explore these questions.

The Clinic: Anorexia *and* Care

Self-starvation is arguably central to a diagnosis of anorexia nervosa, and it is regarded as underpinned by ‘an intense fear of gaining weight or becoming fat’ (American Psychiatric Association 2013). That an individual with anorexia often ‘neither gives up in the face of the negative consequences of eating restraint (not least hunger)’ (Palmer 2014: 5) means that anorexia has ‘one of the highest mortality rates of all psychiatric illnesses’ (Bogle 2000: 2). Although ‘most patients with anorexia nervosa receive treatment solely on an outpatient basis [...] a substantial minority receive inpatient treatment’ (NICE 2004: 6.5.2). It is suggested that ‘patients may require inpatient care if they are suicidal or have life-threatening medical complications [...] or weight below 85 percent of their healthy body weight’ (Williams et al. 2008: 187).

Treatment can be enforced in England through sectioning under the mental health act ‘where substantial risk cannot be managed in any other way’ (NICE 2004: 6.5.7.3), although only ‘a relatively low proportion of inpatients with anorexia nervosa are placed on formal compulsory treatment orders, with reports ranging from 9% to 28%’ (Tan et al. 2010: 14). The justification for enforcing treatment is underpinned by framing individuals with anorexia as lacking the capacity to make decisions regarding treatment as a result of their compromised physical state (see Giordano 2005). On the other hand, scholars have argued that accepting an individual’s treatment refusal can be ethical, especially if this is an autonomous decision against a background of frequent or repeated treatment failure (See Draper 2000; Matusek and Wright 2010). Attention on the part of medical ethicists in recent years on values, seeing these

rather than individual autonomy as affected by the illness, has also challenged an assumed loss of capacity in anorexia, thereby furthering complexity (see Tan and Hope 2008). As such, anorexia and its care present to professionals a matrix of complex issues.

However, it has been suggested that if we accept that ‘anorexia nervosa is not inevitably a progressive terminal illness [...] it is preferable that treating physicians focus on the preservation of life’ (Melamed et al. 2003: 62). Given the risks of severe emaciation and the ‘intensive care’ (Treasure and Schmidt 2005: 95) required by the starved body, it is clear how from a clinical point of view, ‘there is no doubt that the appropriate treatment is food’ (ibid. 95). Thus, although guidelines state that ‘weight gain is only one outcome of interest’ (NICE 2004: paragraph 6.4.9), arguably ‘the common goal is to re-feed the patient’ (Griffiths and Russell 1998: 128), particularly in inpatient treatment. As such, although the heterogeneous nature of clinical practices must be acknowledged (see Berg and Mol 1998) with differing approaches existing alongside widespread recognition that psychological input is key, it is clear that food is a central vector of care. Glimpsed through the regular weigh-ins of outpatient treatment, where food consumed since the last appointment is measured through the body, this caring through food is most starkly brought to the fore in daycare and inpatient treatment.

On the eating disorders inpatient unit (EDU) on which I conducted ethnographic fieldwork, meals are only one part of an extensive programme of psychological support. Yet a pervasive focus on feeding structures the temporal rhythms of the unit as all other activities, from recreation to therapy, are arranged around mealtimes. If I bumped into someone I had not seen for a few hours and asked them what they ‘had been up to,’ many would reply with humour, ‘eating!’ As one participant, Kate¹, put it, ‘every day is just, sort of, eating, to be honest [...]. My whole life is planned around meals’. Likewise, in her interview, Abigail said:

¹ All names are pseudonyms.

They [staff] always tell us ‘you have to eat, it’s normal’. Oh yeah, cos, everyone has a sandwich an hour after they’ve had lunch! [...] All they do in inpatient treatment is feed you, food, food, food, more food....I wish they’d admit that all they do is feed you and then let you go. I just wish they’d admit that, or warn you that’s what’s going to happen when you go in. They say they’re going to change you and... and help and stuff. But they don’t, they just make you fatter (Abigail, inpatient, 2008).

It frequently infuriated participants when staff would not admit that three meals and three Snacks amounting to 3,500 calories a day was, as one participant Chloe put it, ‘a shed load of food.’ Peter, a temporary psychiatric nurse charged with the task of watching over lunch on his first day on the unit exclaimed in a loud whisper to the service user eating next to him, ‘gosh you really do have to eat a lot, don’t you!’ He was thoroughly chastized for this in a subsequent staff meeting but participants discussed how they ‘appreciated his honesty,’ which was contrasted to the discursive norms of the unit. These norms are twofold: On the one hand, as Abigail suggests, there is a framing of eating as ‘normal’. On the other, when the amount of food was challenged by service users, staff would frequently move away from attempts at normalization to instead tell service users that ‘whilst you’re on the EDU, food is medicine’ (see also Long et al. 2012). This discursive framing positions mealtimes as clinical events that transact a substance – medicine – to be taken for one’s own good. In turn, any refusal to eat on the part of service users comes to be seen (and perhaps also felt by staff) as a refusal of their care.

On the EDU such refusals to eat, alongside vocalizations of distress at eating or desire to talk about food or weight on the part of service users were often described by staff as ‘the anorexia talking’ (see Tan 2003). This conceptualizes such articulations as ensuing from a loss of agency to anorexia and sees the illness as a current and temporary addendum to a patient’s

‘authentic self’ (Bruch 1974; Tan 2003). It suggests that ‘the individual doesn’t really want to restrict her eating, lose weight, or resist treatment - her Real Self has been invaded/infected/colonized by an Outside Force’ (Vitousek 2005: 3). Expounding such a clear division aims to encourage service users to externalize their anorexia and thereby re-find - literally recover – an illness-free self that is conceptualized not only as having become trapped in, or effaced by, anorexia, but also as having preceded it. What is advocated, thus, is a change back into what one once was and, perhaps, *should* be again. This elucidates, as does this volume more widely, that ‘caring is an activity in which (often moral) valuing is implied’ (Heuts and Mol 2013: 130. See also Barnes 2012).

To claim that not eating, or refusing the caring-as-feeding on the EDU, on the part of an anorexic individual is not an autonomous or ‘authentic’ decision in this way does save lives. It forms part of the architecture that justifies enforcement of treatment under the mental health act, noted above. Yet, this not only is underpinned by a particular value-laden paradigm of selfhood and pathology but also offers a way in which to perform this as care; it cleaves a conceptual space between anorexia and self into which caring through food can be fitted. This - in relation to Fisher and Tronto’s (1990) four dimensions of care – forges a pathway from ‘caring *about*’, framed as attentiveness, to ‘Caring *for*’, framed as the work of caring (see also Tronto 1993; Ungerson 1983). Eating thereby becomes the vector through which selfhood is rematerialized through the measurably-expanding body - literally dripped back in through the swallowing of every mouthful. The so-called ‘authentic self’ is at once the receiver and also goal of care, and is thereby positioned tensely within two temporalities at once. Food, likewise, is both the focus of this work, and also made to work in a particular way.

Exploring these feeding practices as a form of foodwork highlights how nutritional value takes precedence over any other aspect of the sticky materiality of food. As food becomes medicine, bodily perimeters likewise become linear markers of illness or health, whilst intimate

trajectories of food through corporeal spaces are rendered paradoxically ‘immaterial’; food as a vector of care does not ‘matter’ in and of itself. In their exploration of care and food in a nursing home, Harbers et al. (2002) show how food is constructed differently within ethical and medical discussions of food refusal and feeding in the context of dementia. A ‘medical attitude to food (appreciating it for its nutritional value)’ (ibid. 216-17) is contrasted to an ethical paradigm of food as a ‘means to an end: survival, that may be desirable or not’ (ibid. 217). On the EDU, as the nutritional value of food also becomes enfolded into survival as an end goal, these discourses merge to coalesce into one teleological production of food *as* care. Yet, not only is the sensory materiality of food missing from this, but so too, perhaps, is the lived experience of being cared for.

To suggest this is not to deny the care that is conducted in the clinic; participants invariably recognized its value for other service users if not for themselves. However, many also described the EDU as ‘terrifying’ and ‘awful’, with mealtimes the focus of their fear and distress. Harbers et al. argue that a caring attitude is one ‘which tries to accommodate and please a person’ (2002: 217). Arguably the EDU’s foodwork, and its underpinning in ‘the anorexia talking’, dislocate both caring and eating from ‘pleasing’ not only in terms of the materialities of food but also of the person. The person, it is suggested, is currently absent as the present is *filled* only with anorexia, which must be replaced by food. As such, the anorexia of the *present* is worked on through foodwork in order to teleologically care for the self of the *future*. If, then, care comprises sustained ‘tinkering towards improvement’ (Heuts and Mol 2013: 125. See also Mol et al. 2010a), it is clear that the EDU’s foodwork does care but that it does so in a way that sees improvement as both in the future and in the body.

Foregrounding the feeding of the body as the central element of care serves to locate anorexia *in* the body. It is clear that the suffering body is arguably one of the few ways that anorexia can be clinically ‘grasped,’ in order that individuals may be cared for and so this

positioning is pragmatic. However, it also serves to make bodies *essentially anorexic*, and anorexia *essentially bodily*. Bodies thus are arguably not only made in the literal sense of nourishment on the EDU, but also in a more conceptual way; the clinic maps a particular paradigm of anorexia through the corporeal depths of digestive geographies (see Willems 1998). It is against the background of this particular arrangement of self, body and anorexia performed by the clinic's ways of caring that we now turn to engage with narratives of individuals with anorexia. From these emerge alternative arrangements of anorexia and corporeality, illness and self.

Anorexia as Self-Care

In her interview Tammy recounted how her anorexia 'was never kind of a deliberate diet to lose weight or anything like that'. She said: 'it's never been so much of a body image problem for me, it was more just kind of not wanting to eat and kind of regaining control over that'. Tammy described how control was gained not only by ingesting as little as possible without dying, but also by an accompanying preoccupation with food that we might term 'virtual foodwork'. This was apparent in Lacey's interview:

I remember sitting on the bus on the way back from school [...] And I got off the bus and I realized that I'd spent the entire bus journey counting the calories that I'd eaten that day, and that I was going to have to eat when I got home. And then I was thinking about the calories that I'd eaten all week and all that kinda stuff and it was like...like looking back on that, it was just like I was thinking about probably so I don't have to think about everything else (Lacey, daypatient, 2014).

I have explored elsewhere how practices, such as calorie counting and restricting food intake, which both enact and enframe *not* eating, illustrate that self-starvation does not simply

constitute a lack in anorexia. Rather, it comprises continual work in order to engender ‘relationships of absence’ with food through which anorexia is processually maintained (Lavis 2013). The illness is therefore both dependent upon, but also of greater significance than, practices of not eating. As such, the foodwork of not eating here is, on the one hand, in opposition to that of the clinic. Yet these also share, and set to work, a conceptualization of food as quantifiable in a way that belies any sense of its sticky materiality. Above, I suggested this effacement in the clinic to be produced by the enfolding of a medical model of food into an ethical paradigm of saving lives. In participants’ narratives now, food’s materiality is again obscured in its intertwining with particular productions of value. However, these relate to the space of the present rather than future, as foodwork emerges as a way of producing anorexia to care for the self. This takes us beyond the clinic’s binaries of self and Other, future and present.

In her interview, Josie, described her self-starvation and the virtual foodwork that accompanied it as:

A distraction and an escape from the real world, the pressures, the worries, the stress, things that I couldn’t control, things that I didn’t know how to handle. It’s a really easy thing to focus on and to let take up your mind [...]. It was something to focus on that didn’t hurt, that I could control when I couldn’t sort out some of the other issues (Josie, inpatient, 2014).

That not eating offers a way of controlling and numbing emotions is recognized; anorexia has been described as ‘a functional coping strategy in which control of eating serve[s] as a means of coping with ongoing stress and exerting control’ (Eivors et al. 2003: 96. See also Treasure et al. 2007). Yet these accounts of ‘counting calories’, and thereby ‘escap[ing] from the real world’, also suggest that the numbness offered by virtual and actual self-starvation goes beyond the control of emotions. By letting anorexia ‘take up your mind’, as Josie put it, there would

seem here to be an agential absencing of the self that both maps onto and yet, importantly, also contrasts with the conceptualizations of self and illness in the clinic, above. In her interview, Claudine said:

You just sit there and sometimes it [anorexia] manifests itself in a sort of numbness and I'll just lie on my bed, stare into space and I'll sleep a lot or something like that. I just want to stop thinking and you do almost zone out as it were (Claudine, inpatient, 2008).

In many participants' accounts there is a slippage between this zoning *out* through anorexia described by Claudine and the illness as a space to zone *into*. Anorexia was described by one participant as 'my space' and another as a 'my little bubble', with Emila saying 'it's almost like it's a world that you live in, that's separate from everybody else'. In her interview Nita described this spatiality in terms of safety. She said that anorexia had 'been a safety net for so long, removing it is the scariest thing in the world. [...] I think that's what has stopped me getting better completely and being fully recovered, is that it's a safety net that I don't want to remove'. She continued, 'it becomes so much a part of you' and asked, without it, 'what would I be?'

The sense here of anorexia as a 'safe space' that offers 'retreat' is reminiscent of Ellen Corin's discussions of 'positive withdrawal' (Corin 2007) in psychosis. Corin suggests that withdrawal signifies a way to 'defend an inner space' (ibid. 283) through the construction of a kind of 'psychic skin that parallels the social skin' (ibid. 283). Reflecting on anorexia as 'psychic skin' illustrates that the illness, as a space of numbness or retreat, is not empty; it does not comprise a gap where the 'authentic self' used to, or should, be. Rather, in participants' accounts anorexia stills the present in a way that forges an alternative subjectivity of space and being; this is a space *for* and *of* selfhood whilst also, importantly, being recognized as a space forged through illness. Yet, this is not to see the self simply as suspended or held within anorexia. Rather, selfhood 'manifests', to borrow Claudine's word, within and with the illness.

Whilst poignantly elucidating how the cleaving attempts to remove anorexia from self on the part of the clinic may be experienced as care-less rather than care-full, Nita's questioning of 'what would I be' without anorexia, evinces an 'intersubjective fusion' (Jackson 2002: 340) with the illness that runs through many participants' narratives. Thus, if the foodwork of not eating processually maintains anorexia for participants, it also maintains their sense of self. In so doing, it is felt to be a modality of self-care that mediates how they live and move through the present moment.

Kate described anorexia as 'how I do things. You do it quietly, you do it on your own'. Likewise, Elisa said of anorexia that it 'would be probably the only thing in my life that's been constant for the last, I don't know, seven or eight years or something and I guess it's become a part of me and a part of my routine'. These descriptions of anorexia as 'part of my routine' and 'how I do things', afford a glimpse into how, to participants, anorexia may be a way of making and mapping the space of the present; not eating thereby 'craft[s] more bearable ways of living with, or in, reality' (Mol 2008: 53). The foodwork of not eating, albeit ambivalently, mediates how participants encounter the worlds around them; it processually reproduces an illness that offers a way to withdraw from, or interact with, these. Such a conceptualization of the illness as 'crafting' the present is contrasted in some accounts with the uncertainty signified by the future. As Elisa put it, 'you don't quite know what the future holds' and, to her, this emphasized anorexia's safety. Thus, if caring comprises 'persistent tinkering in a world full of complex ambivalence and shifting tensions' (Mol et al 2010 B: 14), anorexia offers a way of caring for the self that navigates tensions; or, as Leila put it, 'anorexia looks after you'.

This sense of self-care through anorexia clearly diverges from the clinic's conceptualization of the illness. But there are also overlaps not only between ways of caring but also between how the clinic and participants envision the object of care. In the EDU the so-called 'authentic self' was at once the receiver and also goal of care, which positioned it within

two temporalities at once. Here, as anorexia itself emerges as a modality of care, the self is cared for in the space of the present moment, but in a way that may not offer any other temporality. Caring through not eating performs stasis rather than teleology, with all the ambiguity that ‘stasis’ suggests.

There is a precariousness to anorexia as a modality of self-care; its safe space is potentially consuming. Josie illustrated this in her interview by saying, ‘I felt like I wasn’t existing’. This slippage from a space of selfhood to one of effacement was also described by Lacey, who said the process from one to the other was ‘like rolling down a slope’. Yet, despite the distress expressed at this sense of a loss of agency to, and sometimes betrayal by, anorexia, participants do not always wish to give up this particular modality of self-care; rather, their narratives evince an accommodation to the ways in which caring may be a deeply painful activity. This was clear in Hadia’s interview when she recounted how she would sometimes sit and just, as she put it, ‘be alone with anorexia’; she described feeling ‘safe’ and ‘okay’ in this space. But, Hadia also described how she would sometimes feel her anorexia becoming too strong, too entrapping in a way that ‘pushed [her] out’. Yet, instead of this statement signifying a wholesale alignment with clinical conceptualizations, within it diverging paradigms touch edges before quickly parting ways. In order to care for herself within this entrapment, Hadia described working harder at her foodwork to processually reproduce the space of her illness and align herself with(in) it.

It was arguably therefore her experience of anorexia’s narrowing of possibility that led Hadia to continually re-invent it as ‘[her] space’. In this, she illustrates that ‘people make-do with what they have’ (de Certeau 1984: 18), whilst also showing that anorexia as a mode of self-care could be regarded, following Plato, as a ‘pharmakon’ (2005; Derrida 2004); it is not only both remedy and poison at once, but, importantly, remedy for its own poison. Evincing the doubledness encapsulated by the preposition ‘through’, self-care through anorexia sees

anorexia as at once a vector of caring, but also as something that is difficult to live through. These become enfolded as participants like Hadia work harder to catch up with anorexia so that it may continue to ‘look after’ them. The illness is thus a way ‘to live with what would otherwise be unendurable’ (Fischer 2007: 423), where the unendurable may be at once cause and effect.

Therefore, care-full dynamics of ordering and producing the everyday through the foodwork of not eating have been seen to enable a particular selfhood to emerge, albeit it painfully and precariously, within and through anorexia. This, however, does not simply constitute a reversal of the clinic’s paradigm of selfhood as in opposition to anorexia. Rather, the processual mapping of the present in participants’ discussions points to an imagining of selfhood that is less bounded. Although anorexia as skin and space seem de-relational, there is a complex sociality to many participants’ narratives. Returning to Corin’s metaphor of ‘psychic skin’ (2007: 283) illuminates this sense of connection as well as disconnection. As Michel Serres reminds us, skin is porous as ‘in it, through it, with it, the world and my body touch each other’ (2008: 80). Therefore, extending the existing sense of anorexia as that which maps inner worlds, the final section will now explore a more relational ordering enacted by participants through the careful sociality of foodwork. If, in rematerializing the self through the body, the clinic performed care in a paradoxically dual and yet embodied way, in this discussion of anorexia *as* care the body has hovered at the periphery of the page, seemingly unrelated to anorexia or food. By now turning to explore how not eating cares for Others, troubled and troubling bodily materiality is brought, finally, into analysis.

Careful Sociality: (Not) Eating (and) Others

In her interview, Rashida described how she had begun to self-starve after her father had been hospitalized for a terminal illness. She poignantly recounted having watched him ‘shrinking

away’ and feeling that if she could ‘just eat less than him’, so that he would never become smaller than her, ‘things would be okay’. Likewise, Elisa said of her sister’s hospitalization when they were children:

What I really remember hating when she was ill is seeing everyone else at school and all of her friends and all of my friends carrying on as normally and being healthy and laughing with each other and I really hated that because, you know, my sister was in hospital, it was like the end of my world, um, and I think I want, I wanted that to be marked and almost by punishing myself and by making things bad for me I was marking that and almost not putting myself in the same boat as her but giving myself something, something bad because I would have preferred it was me to be ill (Elisa, outpatient, 2014).

Both Rashida and Elisa’s accounts echo the discussions above of not eating as a modality of gaining control, particularly in emotionally distressing situations. Yet, they also evince the painful partiality of such control, as not eating may successfully map and maintain the space forged inside anorexia but is powerless beyond this. We might therefore be tempted to suggest that here we are confronted with the limits of conceptualizing – or even, experiencing - anorexia as caring. Yet, reflecting again on not eating as active foodwork takes us beyond this to illuminate the place of emotional labour in this discussion; this elucidates how food, and its lack, are set to work here in a way that performs caring about Others.

In contrast to explorations of the caring implicit in commensality (see Carsten 1997), Rashida and Elisa’s narratives frame the sharing of a lack of food as engendering threads of care between bodies and persons. If care is at once ‘both a practice and a disposition’ (Tronto 1993: 104) and the last section’s discussion of self-care explored practices, care emerges here as an embodied disposition. In their felt powerlessness to care for their family members in any

other way – to map the future or, indeed, present for their loved ones - Rashida and Elisa entangle their bodies into a performance of care, enacting a mimetic alignment. Elisa's words that she 'would have preferred it was [her] to be ill' frame her not eating as a 'somatic mode of attention' (Csordas 1993). That this may be at once 'attentive' (Fisher and Tronto 1990) and yet not necessarily fully agential resonates through Elisa's words above, and elucidates that not eating may be a way caring *about* in the face of an inability to care *for*.

Although Rashida and Elisa's performances of care are embedded in the intimacies of familial relations, a similar mimetic alignment of suffering bodies, but across geographical distances, occurs in other participants' narratives of not eating. Some described how they had been chastized as children for not finishing their plates with variations on the line 'think of the starving children'. They related this to a need to not consume 'too much', which was enacted through anorexia. Similarly, in her interview, Juno likened her not eating to the sponsored 24-hour famine established by the charity *Vision UK*, in which participants raise money to aid victims of famine. Recent work has illuminated how eating is an act that engenders webs of sociality between eating bodies across spatial and temporal distances (Abbots and Lavis 2013). This has extended discussions of commensality to explore food as a substance that travels across distances, be those affective, material or both. Here Juno's words, instead, evince the sociality of shared absence; not eating mobilizes caring as an engagement with Others that seeks to 'maintain' or 'repair' the world (Tronto 1993: 102–103). It signifies an attentiveness forged through 'recognizing the needs of those around us' (ibid. 127). It was Milla who most deeply expressed this during her interview; she described her anorexia as both 'an illness' and also 'a sort of testimony to the wrongness of the world'. In so doing, she referred to the philosophy of Simone Weil. It was Weil herself who wrote about attention that it 'consists in suspending thought, leaving it available, empty, and ready to be entered by its object' (Weil in Little 1988: 130). As such, together, 'testimony' and 'attention' articulate a sense of self-

suspension that navigates between anorexia as self-protection and self-loss, whilst also intertwining these with the care of Others. Milla recounted how she was told she was ‘too global’ by staff in the EDU who felt she should ‘focus on [her]self’:

I know I’ve been told over and over again ‘your, your protest won’t stop exploitation in the third world just because you know, you boycott coca cola it isn’t going to stop them cutting down the rainforests’.... Erm and, ‘what do you think the starving people would say if they saw you doing this to yourself?’ All this stuff. Of course I know, of course I know (Milla, inpatient, 2008).

It is perhaps as anorexia compromises conditions of possibility in the mingled protection and engulfment, seen above, that caring for Others offers a way of being oneself through the alternative becoming of mimesis. As such, linking one’s self-starvation to other suffering bodies across geographical distances also reinforces a particular modality of self-production. It allows anorexia to be reinforced by the body of an imagined Other. The illness thereby becomes, at once, legitimized and moralized.

Scholars have previously explored anorexia in relation to cultural discourses of morality, arguing that ‘anorexics [are] misguided moralists’ (O’Connor and Van Esterik 2008: 7). It has been suggested that eating disorders ‘are the symptoms of ordinary morality, which is just being taken seriously – or more seriously than usual’ (Giordano 2005: 8–9). Yet, with a few exceptions (see Gooldin 2008; Warin 2010), such discussions have tended to focus on anorexia’s intersections with the wider cultural valuing of ‘purity’ and ‘lightness’ (Giordano 2005: 127) in a Euro-American context. Here, instead, it is food itself (and its lack), rather than the secondary effect of this on bodies, that emerges as a ‘moral choice’ (Coveney 1999: 33). As self-starvation maps nascent forms of careful sociality, it becomes ‘an attempt to meet the other morally’ (Noddings 2013: 707). This intersects with wider enactments of ethically

concerned consumption (see Miele and Evans 2010) whilst also framing not eating as ‘a moral achievement’ (Tronto 1993: 127).

Yet, drawing on a moral framework in this way is also performative; it serves not only to mime and mediate Others but also produce them, mapping other bodies and other hungers over those of participants. As such not eating as a somatic modality of attending to the suffering of others enacts a complex interplay of visibility and invisibility. We saw this in the entangling of Rashida’s body with her father’s, above, as her not eating sought to nourish him by effacing her. Moreover, in this wider discussion of care in a global context, caring through not eating simultaneously forges links between bodies based on suffering, whilst also recognizing - or, perhaps, feeling - only the suffering of the Other’s body. This gains a hyper-visibility whilst that of participants is maintained as peripheral. The doubledness and dualism in this is elucidated by turning to one participant, Michelle’s, slippers.

‘What can one say, I ask, about a slipper?’ says Michel Serres (2008: 64). In the EDU many things were asked and uttered about Michelle’s slippers. These were old, worn and not a little battered; her toe came through the end of one and the stripes had faded to grey. Staff often tried to convince Michelle to buy a new pair of slippers, drawing her attention to their visual appearance, which they described as ‘uncared for.’ To staff, thus, keeping these slippers was indicative of a wider lack of self-care. By delinking Michelle’s slippers from anything but her body and her anorexia through this paradigm of self-care, the clinic thereby bound these together, as we saw above. Yet, Michelle felt that her slippers ‘would do’ as to replace them when they still ‘worked as slippers,’ as she put it, would be ‘wasteful.’ To Michelle her slippers were precisely ‘a place of seams, mixture and marriage’ (Serres 2008: 66), entangled with her wider ethic of care as ‘not consuming too much’. Michelle justified keeping her slippers by saying:

The way society is now it just seems so complex and in terms of consumerism [...] there's this constant effort to produce a new variety or just something different. Or just, 'new extra this' – even cornflakes, you know, 'extra crunchy' with 'extra added this' 'added whatever', something that people think might be good for their health or improve their teeth of whatever.... Or types of teabags! It's just ridiculous the amount of choice. And there is just such a lot of waste and it creates, whether it's about food or anything, it creates an attitude that it's ok. But the amount of waste we produce is just ridiculous and it's actually shameful I think. Some people elsewhere would do anything for the minutest thing we throw away (Michelle, inpatient, 2008).

Thus, to conceptualize Michelle's footwear only as metonymic of a lack of self-care enacted through not eating would privilege the visual narrative of both her slippers and her body over her voice. This would, perhaps, be care-less rather than care-full. Yet, the staff's discussions of Michelle's slippers have also highlighted a tension between embodiment and disembodiment that has resonated throughout this discussion of careful sociality. On the one hand, it has become clear that anorexia is about far more than a quest for corporeal emaciation; complex, relational and intimate practices of caring have shown the illness to be embodied and yet not *about* the body as a visual entity. As, at once, a profoundly 'somatic mode of attention' (Csordas 1993) to others that forges affective links through bodies and their suffering, anorexia has also paradoxically emerged as something that effaces the body and enacts dualism. As not eating *as* self-care and careful sociality are contrasted to the clinic's vision of a lack of self-care within anorexia, competing paradigms of care not only frame bodily materialities in diverging ways but also 'interfere' (Haraway 2008) with these. Bodies become caught up in practices of caring for self and Others through food in ways that engender moments of encounter between anorexic ways of caring and those of the clinic.

In her interview Eva described the effects starvation had had on her body; she recounted bones so sharp that when she turned over in bed she felt them scratching against her skin from within and described how her hair had fallen out and her skin dried to flakes. Before entering the EDU she had been frightened that she was about to go blind because her vision was so blurred. Here the somatic vulnerability of Eva's suffering body does seem, in line with the clinic's claims, to disrupt the caring performed by anorexia. Indeed, Tronto argues that 'in order to recognize the needs of others, one must first be attentive to one's own needs for care' (1993: 131). Here then, as in Michelle's slippers, caring for Others and self would seem to be difficult to align (see also Abbots, this volume). Yet, Eva said of this, 'anorexia's got nothing to do with my body. The physical bit's just a symptom of my mind'. In this simultaneous foregrounding of bodily suffering and yet repudiating of the body as 'important' to anorexia, felt corporeal materiality is re-framed as outside the relationship – the careful sociality, perhaps - between anorexia and self. This disallows embodied suffering to disrupt caring. Echoing Hadia's reconfigurations in relation to a felt loss of agency to anorexia, above, here self-care and careful sociality are enfolded and, once again, placed beyond the painful as well as quantifiable perimeters of the body.

This delinking of body and self, importantly, also demonstrates how diverging ways of caring *about, for, through* and *within* anorexia, seen throughout this chapter, converge. This is because it allows Eva to engage in clinical treatment, seeking care for her bodily suffering whilst also holding onto anorexia and its ways of caring. She described feeling 'grateful' that the clinic had enforced her eating and thereby 'taken away the pain, but not anorexia'. We see, thus, how within the intimacies of bodily depths, diverging paradigms and scales of care co-exist and that caring perhaps always entails negotiation of co-existing as well as competing 'goods' (see Mol et al. 2010a). Eva allows herself to be cared for in a way that she feels to maintain her anorexia *and* selfhood. That this permits the illness to continue mapping the space

of the present in ways that care for Eva, warrants recognition as we listen to her narrative. Yet at the same time, it perhaps also suggests that anorexia's 'careful sociality' may be, most of all, with itself.

Conclusion

It is viscerally clear why, in anorexia, 'the story of illness that trumps all others' (Frank 1997: 5) is the clinical. Yet, this chapter has sought to show that there are other stories that need attending to. For both the clinic, and individuals with anorexia, not eating keeps the illness present. Yet what is kept present, and indeed effaced, diverges. To the clinic, anorexia signifies a lack; the present is effaced by illness so that clinical care is both of – and has as its goal the recovery of – the 'authentic self'. Through a food-as-medicine paradigm, eating becomes a linear modality of rematerializing this self, envisaged as lost through self-starvation. In contrast, to some individuals with anorexia, the illness offers a way of living through the present; this is forged and mapped by, but also ambivalently contained within, anorexia. In these narratives, anorexia and self cannot be distinguished so neatly, as the illness offers a space of and for selfhood whilst also performing care about and for (imagined) Others. In the introduction, I called on an idea of bracketing to allow recognition of the clinical realities of anorexia whilst opening up a space in which to explore beyond these. As the chapter has unfurled, we have seen how these are also in tension in the lives of participants; illness and selves, bodies and pain, eating and caring, are all divergently and procesually positioned and bracketed in relation to one another. In particular, the materialities of foods and bodies have shifted in and out of view as ways of caring have engendered interplays of visibility and invisibility. Alongside this troubled and troubling materiality, it is perhaps both the distress and intermittent loss of agency in participants' lived experiences of anorexia that most problematizes an idea of the illness as care. Yet, it is also both of these that underpin its

importance; caring is cyclical as care of the self necessarily instigates caring for anorexia so that it may continue to ‘look after you’. Thus, this chapter has perhaps most shown that caring about individuals with anorexia depends ‘to an important extent, on one’s sense of empathy and compassion for a person’s suffering’ (2005: 261) as well, perhaps, on listening. By tracing along some of the sharper edges of both eating and caring, the discussion has sought to forge understandings of how care, food and anorexia are all lived and felt, resisted and reconfigured, in ways that disrupt but also ‘matter’ the intimacies of individual bodies, selves and everyday lives.

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